



M-prop Trav. policy

OR 81

WEST JERSEY

Jack J. Staskewicz
Executive Vice President

MEMORIAL PARKWAY
P.O. BOX 110

☐ U.S. 22, EAST ☐ AT FIRTH STREET ☐ PHILLIPSBURG, N.J. 08865
Affiliated With American Automobile Association

201-859-2177

Dear Member:

As a member of the West Jersey Motor Club you have many occasions to travel in various ways and for different reasons. When you consider the miles traveled and, more importantly, the time spent driving your car, riding as a fare paying passenger or just walking around...you will begin to recognize the need for a special kind of protection.

The PROTECTOR, a full time, high limit travel accident insurance policy, underwritten by Keystone Insurance Company, was designed with your needs in mind; whether you travel by air, automobile, common carrier or even as a pedestrian... and keep in mind you are protected 365 days a year; not just for business or vacation trips.

Take a minute to read the enclosed brochure which fully explains the coverage provided and how easily you can have this important, yet low cost protection now. I believe you will agree, it will be a minute well spent.

We are writing to all our members to be certain everyone has this opportunity. To those of you currently enjoying this protection, please excuse this duplication.

Cordially,

Jack Staskewicz

Jack J. Staskewicz
Executive Vice President

JJS/bck
Enclosure

P.S. - This special offer is exclusively for members of the West Jersey Motor Club.

Branch Office ☐

Route 15 ☐ Lafayette, N.J. 07848 ☐ 383-5400

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 629 PHILADELPHIA, PA.

POSTAGE WILL BE PAID BY ADDRESSEE

KEYSTONE INSURANCE COMPANY

ATTN: COLLECTIONS DEPT.

2040 Market Street

Philadelphia, Pa. 19103

0760037438 2 M 1 10 0131 #
THEODOR NELSON
BOX 128
SWARTHMORE PA 19081

Information required for issuance of The:

PROTECTOR
(PLEASE PRINT)

Exclusively for members of

WEST JERSEY MOTOR CLUB



NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
DATE OF BIRTH (Month) _____ (Day) _____ (Year) _____
BENEFICIARY (If other than spouse) _____ RELATIONSHIP _____

Check Plan Desired:

Annual Premium:

Plan I—\$100,000

Plan II—\$50,000

Individual

☐ \$26.00

☐ \$15.00

Family

☐ \$36.00

☐ \$21.00

I understand and agree that coverage is effective on the day my certificate of insurance is received by the company.

AGENCY CODE: 03400-76

DATE _____ MY SIGNATURE _____

Please make check payable to: **KEYSTONE INSURANCE COMPANY**, Philadelphia, Pa. 19103

ACC58R